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Postprint / Postprint

Zeitschriftenartikel / journal article

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Empfohlene Zitierung / Suggested Citation:

Stevenson, F., & Scambler, G. (2005). Rejoinder to 'The myth of concordance': a response to Armstrong. *Health*, 9(1), 29-30. <https://doi.org/10.1177/1363459305048095>

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Rejoinder to 'The myth of concordance': a response to Armstrong

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Armstrong presents our original article as based on two arguments, firstly that the trust patients have in their doctors has declined in recent years, and secondly that it follows from this that as concordance assumes open communication between doctors and patients it is now becoming impossible to achieve. This is an over-simplification of our argument. We examine concordance against the background of changes in society, focusing in particular on challenges to trust, and argue that concordance is being espoused at a time when the prospects of its accomplishment may be reducing. Rather than achieving the open and honest exchange of views typically regarded as necessary for concordance, it seems possible that communication between patients and practitioners may be distorted, not least because patients feel trust in their practitioner has diminished. Rather than arguing, as Armstrong does, that concordance is impossible to achieve, we highlight possible pitfalls associated with putting the model into practice.

Trust

Armstrong neither accepts our definition of trust nor agrees that it has diminished. He appears to contend that the case for *or against* declining trust cannot be made empirically; then he opts for the latter. We point to evidence of diminishing trust in the professions and in expert systems in general, not just medicine, in addition to phenomena such as the increase in litigation against the medical profession. This may indeed, as Armstrong suggests, indicate easier access to legal redress, although it is likely that such an increase would be associated with more than just its availability. His denial of a golden age of trust is a red herring. Our argument is that notions of expertise are changing and unthinking paternalism is on the retreat, particularly in the light of various health scandals widely reported by the media as well as the medical press, which are likely to have affected the way in which medicine is perceived. Armstrong argues that evidence of a diminution of trust in medicine in general cannot be taken as evidence of a diminution of trust at the level of the individual relationship between

doctors and patients, yet surely he cannot be arguing that relationships between patients and practitioners operate in a vacuum and are unaffected by factors in wider society?

With regard to the relationship between trust and communication, we are not arguing that there is a simple relationship between trust and good communication, but rather that trust is necessary for effective communication since people are unlikely to feel comfortable sharing their understandings and beliefs if they do not feel they can trust their practitioner to respond sympathetically. Moreover, concordance will not be possible if patients and practitioners feel unable to trust information from the other party. A decline in trust is likely to increase the challenges for achieving concordance.

Concordance

The article is positioned so as to open up a debate about the feasibility of concordance in practice. It is not, as Armstrong appears to have read it, a prediction of what will necessarily happen. We raise the possibility that a move from compliance to concordance – one which is in part ‘political’ or rhetorical – may in practice result in a shift from open strategic action to concealed strategic action, and significantly to systematically distorted communication. We do not as Armstrong suggests ‘insist’ that this will be so.

Armstrong points to the relationship between shared decision-making and concordance, although he fails to highlight the principal difference between the two, namely that patients do not have to take an active part in decision-making for concordance to occur, while this is a necessary aspect of shared decision-making. Thus concordance allows for greater flexibility for patients to decide on their levels of involvement on individual occasions, allowing for the inclusion of people who may not desire, or feel comfortable with, such a responsible role in the consultation.

To conclude, the aim of the article is not in Armstrong’s words, ‘to present a romantic and idealized view of the potential of concordance and then to claim this dream has gone’, but rather, again to quote Armstrong, to place concordance ‘in a wider context that would allow better understanding of its claims’. The difference between our position and Armstrong’s hinges on the interpretation of the concept of a wider context. Armstrong appears to see the wider context as relating to the history of other academic models of decision-making; in contrast, we perceive the context to relate to changes in the wider society. A final point: it was no more our intention to write as ‘Habermasians’ than it was presumably Armstrong’s to respond as either a Foucauldian or an ironic and playful health services researcher.

Authors’ details on p. 21